

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN8203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  11/09/2011
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  An annual Licensure survey and complaint investigation #28827 were conducted on November 7 - 9, 2011, at Brookhaven Manor. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Christopher A. Gaddy*

TITLE

*Administrator*

(X6) DATE

*11/21/11*

STATE FORM

6899

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If continuation sheet 1 of 1